



September 28, 2011

RE: Statement of the American Speech-Language-Hearing Association Regarding the Hearing on Expiring Medicare Provider Payment Policies

Dear Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee of the House Ways and Means Committee:

The American Speech-Language-Hearing Association (ASHA) appreciates the opportunity to provide this statement for the Committee record related to the September 21, 2011, hearing on expiring Medicare Provider Payment Policies. ASHA is the professional and scientific association representing 145,000 speech-language pathologists, audiologists, and speech-language and hearing scientists. Our comments will focus on the, more than a decade long, effort to repeal the therapy caps and replace it with a system that allows appropriate beneficiary access to medically necessary speech-language pathology and physical and occupational therapy. To that end, we request that Congress extend the therapy cap exceptions process through calendar year 2014, and work with stakeholder groups in the development of a reformed payment policy.

The therapy cap policy is flawed, as it sets an arbitrary cap on beneficiary expenditures that has no basis on the practitioner's clinical judgment on the need for therapy. The caps were developed without the review of patient needs and other relevant data, such as patient outcomes. The policy was meant as a stop gap measure to control costs as the agency establish revised coverage policies based on patient characteristics. In creating the caps, Congress specifically directed the Secretary of Health and Human Services to develop recommendations, as referenced in the following citation:

2) REPORT- By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on the establishment of a revised coverage policy of outpatient physical therapy services and outpatient occupational therapy services under the Social Security Act based on classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of the uniform dollar limitations specified in section 1833(g) of such Act, as amended by paragraph (1). The recommendations shall include how such a system of durational limits by diagnostic category might be implemented in a budget-neutral manner.

Over the past decade, under both Republican and Democratic leadership, Congress either extended a moratorium on the implementation of the therapy caps or more recently supported continued extensions of the therapy cap exceptions process. In doing so, Congress recognizes that placing arbitrary limits on a patient's access to outpatient speech, physical, and occupational therapy is not in the best interest of the patient.

Should this Committee consider alternative payment reforms for outpatient therapy services, ASHA requests that any alternative be based on patient need, risk adjusted to ensure that the most fragile and ill patients receive appropriate services and take into account patient outcomes. Additionally, in order to develop appropriate payment for outpatient therapy services, both Congress and CMS must recognize and maintain each therapy service as a unique and distinct benefit and ensure that coverage guidelines are consistent with professional standards of best practice and clinical decision-making for each distinct therapy service.

Speech Language Pathology Services Under Medicare

Although an important intervention for many Medicare beneficiaries, speech-language pathology services account for a very small percentage of overall Medicare Part B spending. In terms of outpatient therapy expenditures, speech-language pathology services only account for approximately 7%. According to the Centers for Medicare and Medicaid Services, in 2008 speech-language pathologists served approximately 478,000 beneficiaries and accounted for \$336 million in Medicare outpatient therapy expenditures. The average patient received \$702 in services. CMS also reported that when beneficiaries received both physical therapy and speech-language pathology services, 15.3% exceeded the cap.

Speech-language pathologists (SLPs) provide critical services to Medicare beneficiaries in treating complex neurological conditions that may be caused by a stroke, Parkinson's disease or other serious condition. Speech-language pathologists not only work on speech and communication issues, but also work with patients on cognition and swallowing difficulties (dysphagia). In a recent CMS report, dysphagia services was ranked as one of the most frequently administered therapies that speech-language pathologists provide to the Medicare population. Failure to treat dysphagia can lead to malnutrition, dehydration or aspiration pneumonia, both of which extend a hospital stay or require re-hospitalization, thereby increasing costs to the Medicare program.

Under the therapy caps and absent an exceptions process, a beneficiary must divide limited therapy resources between physical therapy and speech-language pathology services. Due to a quirk in the statute, physical therapy and speech-language pathology services are combined under one cap while another cap was established for outpatient occupational therapy services. Due to the nature of the interventions provided by speech-language pathologists and physical therapists, physical therapy is often the first therapy received by a beneficiary. Where more intense intervention is required, it is not usual for the patient to exceed the cap before even receiving speech-language pathology services.

Having to choose between which services (i.e., physical therapy or speech-language pathology) a beneficiary will receive puts the patient at serious risk. Cognitive and communication deficiencies can affect a beneficiary's ability to communicate needs to their caregivers, increase physical therapy due to inability to follow directions, and could lead to potential safety issues. Additionally, failure to appropriately identify and provide services to individuals with communication and cognitive deficits may lead to a failure in providing appropriate interventions, therefore, placing the patient at risk for further medical complications. This may result in higher costs to the Medicare program.

Speech-Language Pathology Reimbursement Under Medicare

Unlike physical therapy and occupational therapy reimbursement, which is based on time-based codes, SLPs bill their services using CPT codes that are non-timed procedure based codes. Speech-language pathologists have specific codes designated for treatment and evaluation. These codes may only be billed once daily regardless of the severity of the patient or the type of intervention provided by the practitioner. With the exception of dysphagia evaluations and evaluations for speech generating devices, SLPs do not use high tech equipment that differentiates the cost of the session. Additionally, CMS regulations do not allow the use of assistants for the provision of speech-language pathology services.

Additionally, SLPs are currently eligible to participate in the Physician Quality Reporting System (PQRS) by reporting functional outcomes measures associated with ASHA's National Outcomes Measurement System (NOMS). NOMS is a data collection system developed to illustrate the value of speech-language pathology and audiology services provided to adults with communication and swallowing disorders. Through the use of NOMS, the association is able to provide its members the needed tools to demonstrate progress and gather data that addresses the challenging questions posed by policy makers, third party payers, and administrators.

Alternatives

Over the past decade, CMS has conducted many studies on patient characteristics and the need for therapy. Most recently it is collecting data through its DOPTA project. Unfortunately, even with data collection efforts underway, there has been no real movement by CMS to develop and test alternative payment systems. Absent this leadership, stakeholders such as the American Speech-Language-Hearing Association and the American Physical Therapy Association (APTA) have moved forward in the development of reformed payment systems for their unique constituencies. However, these systems need further development and would need to be tested to ensure that any new payment system does not adversely affect beneficiary access to outpatient therapy services.

As part of the testimony before the Committee, the American Physical Therapy Association proposed the development of a new system for single visit payment for **physical therapy services** based on the severity and intensity of the service. We support APTA's efforts to refine its coding system, and believe that this will enhance the accuracy of payment for **physical therapy services** and prevent inappropriate billing by non-qualified providers. We, however, do not support APTA's reformed payment system for speech-language pathology services. Research conducted on the data derived from ASHA's NOMS system has indicated that factors, such as severity and intensity of services, do not accurately reflect the cost of a speech-language pathology sessions, but do affect the length of time to achieve a treatment goal.

ASHA is currently seeking to engage in discussions with CMS to initiate a pilot program to investigate the feasibility and appropriateness of an episode-based payment system for speech-language pathology services. ASHA's proposed pilot involves moving from a per session

reimbursement model to a per episode model based on the extensive data collected through ASHA's National Outcomes Measurement System (over 200,000 patient episodes). Using NOMS data, patient groupings have been identified based on their severity and complexity and the number of hours of treatment required achieving progress. These groupings could translate to payment groups based on the cost of the number of hours of treatment each group received. Because the distribution of patients into different groups can be predicted from NOMS data, CMS could further anticipate the annual cost of the Part B speech therapy benefit.

Additionally, ASHA supports efforts to refine the exceptions process and encourages the Committee to work with Congress in identifying ways to implement a cost-effective exceptions process that ensures patients who need services beyond the therapy cap receive those services and minimizes the administrative burden on CMS and providers.

ASHA also supports program integrity efforts aimed at reducing fraud and abuse in the Medicare system. To that end, we are supportive of the concept behind S. 1551, which would require smart cards for both providers and beneficiaries.

Thank you for the opportunity to share our views with the Committee. Should you have any questions regarding our statement, please contact Ingrida Lusi, ASHA's director of federal and political advocacy, by e-mail at ilusi@asha.org or by phone at 202-624-5951.

Sincerely,

A handwritten signature in dark ink, appearing to read "Paul R. Rao", with a long horizontal flourish extending to the right.

Paul R. Rao, PhD, CCC, CPHQ, FACHE
2011 ASHA President